ANNUAL HEALTH HISTORY **DR. MATTHEW E. SCHMIDT & ASSOCIATES**

Date _____

Name _____ **Birthdate** _____

EMAIL _____

Referring physician _____

Primary care physician _____

If you are currently being treated for Diabetes, who is your doctor? ☐ **Referring** ☐ **Primary**

☐ **Other:** _____

***Reason for visit**: _____

- Are you experiencing any of the following **eye symptoms**? ☐ **Right** ☐ **Left** ☐ **Both**

☐ **Blurred reading vision**	☐ **Dryness**	☐ **Tearing**	☐ **Flashes**
☐ **Blurred distance vision**	☐ **Double vision**	☐ **Burning**	☐ **Floaters**
☐ **Sandy or gritty feeling**	☐ **Halos**	☐ **Glare**	☐ **Itching**
☐ **Other** _____			☐ **Redness**

- How long have you had these symptoms? _____

OCULAR/SURGICAL HISTORY

- Have you had any of the following **surgeries**? ☐ **No**

☐ **Cataract surgery**	☐ **Eye muscle surgery**	☐ **Cornea surgery**
☐ **Retina surgery**	☐ **Lasik or PRK Surgery**	☐ **Brain surgery**
☐ **Heart bypass surgery**	☐ **Heart stents or angioplasty**	☐ **Carotid Surgery**

☐ **Other**: _____

- Have you ever been diagnosed with an eye problem or had an eye injury? ☐ **No**

If yes, ***when and what type***? _____

_____

PAST MEDICAL HISTORY

- Are you treated or followed for any **medical conditions**? ☐ **None**

☐ **Arthritis**	☐ **Atrial fibrillation**	☐ **High blood pressure**	☐ **Lupus**
☐ **Asthma**	☐ **Heart attack**	☐ **Kidney disease**	☐ **Rheumatoid Arthritis**
☐ **COPD**	☐ **Heart disease**	☐ **Stroke**	☐ **Multiple Sclerosis**
☐ **Diabetes**	☐ **High cholesterol**	☐ **Thyroid**	☐ **Tuberculosis**

☐ **Cancer Type**: _____ ☐ **Other:** _____

PLEASE COMPLETE BOTH FRONT AND BACK FOR INSURANCE BILLING

FAMILY HISTORY

- Do members of your **immediate family** have **eye/medical problems?** ☐ **No**

Immediate family= father, mother, sister or brother. Please list relationship.

☐ **Blindness**	☐ **Diabetes**	☐ **Cataracts**
☐ **Glaucoma**	☐ **Lazy eye**	☐ **Strabismus**
☐ **Retinal disorder**	☐ **Cancer**	☐ **Heart disease**
☐ **Macular degeneration**	☐ **Other** _____	

SOCIAL HISTORY

- Do you smoke? ☐ **Yes** ☐ **No** If so, **how much**? _____

MEDICATIONS

- Please list your **current medications**, including over-the-counter products and vitamin/herbal supplements. ☐ **None**

☐ **See list provided by patient**

_____

_____

_____

_____

- **ALLERGIES TO MEDICATIONS** ☐ **None**

DRUG: **REACTION:**

_____ _____

_____ _____

Have you ever taken:

Myambutol (Ethambutol)	☐ **Y** ☐ **N**
Flomax or any Prostate Med	☐ **Y** ☐ **N**
Plaquenil (Hydroxychloroquine)	☐ **Y** ☐ **N**

REVIEW OF SYSTEMS

- Do you experience any of the following **symptoms?** ☐ **No**

☐ **Chills**	☐ **Tinnitus** (Ringing ears)	☐ **Cold Sores**
☐ **Dizziness**	☐ **Chronic cough**	☐ **Skin Rashes**
☐ **Fevers**	☐ **Shortness of breath**	☐ **Headaches**
☐ **Night sweats**	☐ **Abdominal pain**	☐ **Numbness or tingling**
☐ **Unintentional weight loss**	☐ **Blood in stool**	☐ **Mood problems**
☐ **Chest pain**	☐ **Diarrhea**	☐ **Excessive thirst**
☐ **Edema** (Swelling of legs)	☐ **Blood in urine**	☐ **Heat or cold intolerance**
☐ **Palpitations**	☐ **Painful urination**	☐ **Easy bruising**
☐ **Nosebleeds**	☐ **Warm, red joints**	☐ **Sneezing and itchy nose**
☐ **Sore throat**		

- I permit my medical information to be shared between treating physicians.

_____

Patient signature